ACUTE DILATATION OF THE STOMACH COMPLICATING TYPHOID FEVER.

BY CUNNINGHAM WILSON, M.D.,

OF BIRMINGHAM, ALA.

ACUTE dilatation of the stomach is a condition receiving at the present time no little attention. I have been unable to find in the literature at my command a report of this condition occuring as a complication of typhoid fever. I report below such a case, which I think of enough importance to call to the attention of the profession.

Miss T., age 22, suspected typhoid perforation. Acute dilatation of stomach. Exploratory laparotomy; recovery. This patient was admitted to St. Vincent's Hospital under the care of Dr. H. S. Ward, on March 30, 1907, at the end of the first week of typhoid fever. On admission her temperature was 103, pulse 100. On the day after admission, the patient had a small hemorrhage from the bowels. With the exception of the fact that she did not take her nourishment well, there was nothing unusual up to April 14, when she began to complain of considerable abdominal pain. This was accompanied by a slight degree of tympany. Pulse ranged from 110 to 120; temperature 102. Patient vomited occasionally. After giving ¼ gr. morphine hypodermically, these symptoms became less in intensity.

April 15. Patient had another attack of abdominal pain. Vomiting at frequent intervals. Tympany much more marked. At 3 P.M. patient's condition was extreme; temperature 102, pulse ranged from 110 to 140 and was irregular in rhythm. Abdomen markedly distended. Abdominal respiration absent through abdominal muscles not definitely rigid. Operation April 15. Under ether the abdomen was opened and found entirely filled with what proved to be a distended stomach. The lower portion of the stomach was tightly wedged in the pelvic cavity and its upper border was found high up in the epigastrium. A stomach-tube was introduced and a large quantity of gas and bile-stained fluid, containing a large amount of mucus was removed. The stomach

now became collapsed and resumed its normal position. Before removing the tube, the stomach was washed out until the fluid returned clear. The abdominal cavity contained a considerable amount of serous fluid. This was carefully mopped out. A quart of normal salt solution was now poured into the cavity and the wound closed without drainage. During the next few days the stomach was washed out several times. The patient made an uneventful recovery. This case was not, strictly speaking, a surgical condition, but the diagnosis was not made before the exploration.